राष्ट्रीय डिजाइन संस्थान
National Institute of Design
ఆంధ్రప్రదేశ్ • आंध्र प्रदेश • Andhra Pradesh

MEDICAL REIMBURSEMENT CLAIM FORM FOR OPD TREATMENT

(To be filled up by the Employee in Block Letters)
(Ref. MAT Rules 2021)

Employee Name:	Designation:
Patient Name:	Relation : Age:
Name & address of the Hospital / diagnostic center / imaging center:	
Doctor's Name:	Treatment Period:
Consultation Fees: (Invoice No. & Date)	Medicines: (Invoice No. & Date)
Medical Test / Investigation: (Invoice No. & Date)	Total Amount Claimed:

Note: Mandatory Enclosures:

1. Copy of Doctor's prescription.
2. Original bills for Consultation / Medicines / Tests.
3. Copy of Test Reports except for X-ray.

Declaration: I hereby declare that the above information is true and the expenditure incurred by me. The person for whom medical expenses were incurred is wholly dependent on me. I agree for the reimbursement as admissible under the rules.

Date: **(Signature of the Employee)**

(AMA Recommendation)
(signature and stamp)

Amount sanctioned as per entitlement and admissibility of Rs. ____________________

(Administration)

Forwarded to Finance Department for medical reimbursement of Rs. ________________

(CAO)